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ABSTRACT

In an urban/rural area with a high demand for children's services but limited resources, an outreach service using standardized treatment strategies was evaluated. The basic intervention strategies consisted of three elements: (1) establishment of specific goals: (2) use of Time-Out: and (3) use of praise and attention to increase desireable behaviors. Success rate was 64.3% overall (including dropouts), rising to 88.7% when dropouts were excluded. Followup three months later showed gains were maintained in 85% of the responding sample. The cost of service consisted of 4.5 hours therapy time, 1.9 hours travel time, and 61.4 miles driven to see each client. The results suggest that this type of program can be effective and relatively inexpensive in areas where there is demand for services, and resources are limited. (Author)

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A LOW-COST, EFFECTIVE COMMUNITY OUTREACH PROGRAM FOR HELPING PARENTS MANAGE PROBLEM CHILDREN

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A number of review articles (Berkowitz & Graziano, 1972; Johnson & Katz, 1973; O'Dell, 1974) have concluded that training parents as behavior therapists is an effective and efficient treatment approach. Tharp & Wetzel (1969) documented the variety of problems that can be treated by using parents as change agents.

Few programs, however, have looked at using these methods as a means of providing services in resource-scarce areas (Wahler & Erickson, 1969) and even fewer have looked at the cost-efficiency of providing such a service (Rinn, Vernon, & Wise, 1975). The program described in the paper was designed to provide an effective service at as low a cost as possible to an area where the demand for children's services were high (approximately 250,000 people in an urban/rural area) and where resources were almost non-existent.

The children's services outreach program was designed and run by the author with the help of an assistant[1] who had a B.A. in psychology. The goal of the program was to provide service to those families who were experiencing problems with young children. Service was aimed at families in which the children who were identified as the problem source met the following criteria:

a) the child was 12 years of age or less,

b) the child was not retarded,

c) the problems were not school problems (i.e., classroom behavior problems and/or a learning disability).

The services offered by the program were provided through home visits except in one highly populated urban/rural area. In response to the large number of referrals from this area, a one-day-a-week clinic was held in the local health unit office. However, home visits continued to be provided for these clients who had no transportation.

[1] Many thanks to Linda Robson for her large share in organizing, running, and evaluating the program, and for being such an effective therapist.

Services were generally provided by using the parents as change agents for the family. In almost all families, a basic intervention program was implemented in which the parents were: a) taught to set specific behavioral goals and communicate these to the children; b) given a procedure to deal quickly, effectively and simply with misbehavior (Time-Out); and c) shown how to use their praise and attention to improve their children's behavior and to increase harmonious family relationships.

Parents who requested help from the program usually presented a child (or children) as being the main problem in the family. They usually had specific complaints about this identified problem child, and requested help in improving this child's behavior. The following data is presented with the identified problem child being the focus of the family complaints.

Demographics

Between September 1, 1976 and August 31, 1978, a total of 240 families were seen by the two therapists working in the program. While the identified problem children numbered 245, if one considers that the program was directed at dealing with all of the children in the family, a total of 526 children was affected by the program.

Of the 245 identified problem children, 159 were male and 86 were female. Ages ranged from 3 months to 12 years 11 months, with a mean age of 6 years 6 months.

Presenting Problems

No attempt was made to label children, identified as problems by their parents, with any kind of diagnostic label. Whether the child was labelled a "behavior problem," "hyperactive," "emotionally disturbed," or anything else, either by the parents, teacher, or other professional, the therapist concentrated on identifying the things the child was doing that caused him to be labelled.

An intervention program was then designed with the objective of changing the child's behavior (emotional, attitudinal, verbal, and motor) such that the child was viewed as "normal" or "well" by those persons who were complaining about him.

Problems dealt with in the program were classified into one of six categories. Usually the categorization was differentiated on the basis of the type of programming that was set up to deal with the problem. While all families were given the basic program described in the introduction to deal with Emotional/Behavioral Disturbance, some behaviors required other forms of intervention (i.e., a token economy system). In some cases, a behavior which would have been subsumed under Emotional/Behavioral Disturbance, was extreme enough or different enough to be labelled outside this class of behaviors, and then it was listed under "other." For example, fire setting, refusing to eat anything but bread and butter and Cheerios, or refusing to follow a diabetes regimen, came under this heading.

Table 1 shows the six categories and the distribution of problems.

Insert Table 1 about here.

Success Rate with Problems

Success with a case was rated according to the parent's reported satisfaction with the behaviors complained about in the identified problem child. Five categories for rating outcome were defined (See Appendix B for full description of ratings):

1 - Problems resolved to parent's satisfaction

0 - Failed to resolve problems

2 - Family refused service

3 - Lost contact with the family

4 - Family would not follow program.

Figure 1 shows the outcome of the 317 identified problems.

Insert Figure 1 about here.

Overall, 64.3% of the presenting problems were satisfactorily resolved. However, in a large proportion (27.1%) of the problems, the families either refused service, would not follow the program, or lost contact with the therapist. If only those problems are counted for which families worked with the therapist until mutual agreement was reached to terminate, the results are even more impressive.

Insert Figure 2 about here

For those families who cooperated with the therapist, four out of five cases were resolved satisfactorily. In the case of Emotional/Behavioral Disturbance (which occurred in 70.4% of the identified problem children), 93.8% of the problems were satisfactorily resolved.

Follow-up

Follow-up questionnaires (Appendix C) were mailed to each family three months after its file was closed. Eighty one of the 245 families returned the questionnaire (32.7%). The success rate on follow-up of problems that were satisfactorily resolved at termination is show in Table 2.

Insert Table 2 about here.

Total overall effectiveness after 3 months was 91.4%.

The treatment program not only had a high rate of effectiveness, it was also relatively inexpensive. Cost-effectiveness data showed that the time from a referral to the first visit with a client ranged from 2 to 846 days with a mean duration of 80.9 days.

The time spent in visiting and phoning the family, referral agents, and collateral contact was tabulated and the time taken in traveling to see the client and the mileage involved were recorded. The mean for each of these is shown in Table 3.

Insert Table 3 about here.

The total therapy time involved in each case is 4.45 hours. Travel time adds 1.95 hours, or another 44% to the man-hour cost of seeing the client. Administrative costs (case notes, letters, summary reports, etc.) are not included in this cost analysis. However, if we add 50% of the therapy time to account for administrative costs, the total man-hours required to service each case (therapy time, travel time, and administrative time) is still only 8.6 hours. This is a remarkably low cost to serve a client, particularly when coupled with the high success rate of the intervention.

Summary

The community outreach program served 240 families and 245 identified problem children who presented 317 identified problems.

Successful intervention was assessed in terms of the client's expressed satisfaction regarding the resolution of the problems they brought to the therapist. Success rates ranged from a low of 64.3% for all cases (including drop-outs from treatment) to a high of 88.7% when drop-outs were excluded.

Emotional/Behavioral Disturbance responded best to intervention (93.2%), and stealing responded least well (60%). Follow-up questionnaires from 81 clients showed that success was maintained in 85.1% of all cases after three months. 87.6% of the clients expressed satisfaction with the service (see Appendix C). Favorable comments were expressed by 59% of the clients on follow-up, i.e.,

"...helped me sleep nights...more relaxed...lost 27 pounds and feel great. Thanks again for all your help."

"Before I took Brian for counselling I never knew how he would react anywhere and anytime. Now we have no more surprises. Thank you very much for your help."

"...service was of great benefit to us...(should) have it (service) more widely publicized."

"I just have praise for the service given to me. Thank you very much!"

"...I would highly recommend this counselling to others."

The program is extremely cost-effective, requiring an average of only 4.45 hours of therapy time per client. Total estimated time to serve a client was 8.5 hours, including travel time and administrative costs. The high success rate and relatively low cost of delivery service recommend the use of this type of program in an area where there is a high demand for service with limited resources to serve that demand.

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Figure 1: Outcomes of Intervention with Identified Problem Categories

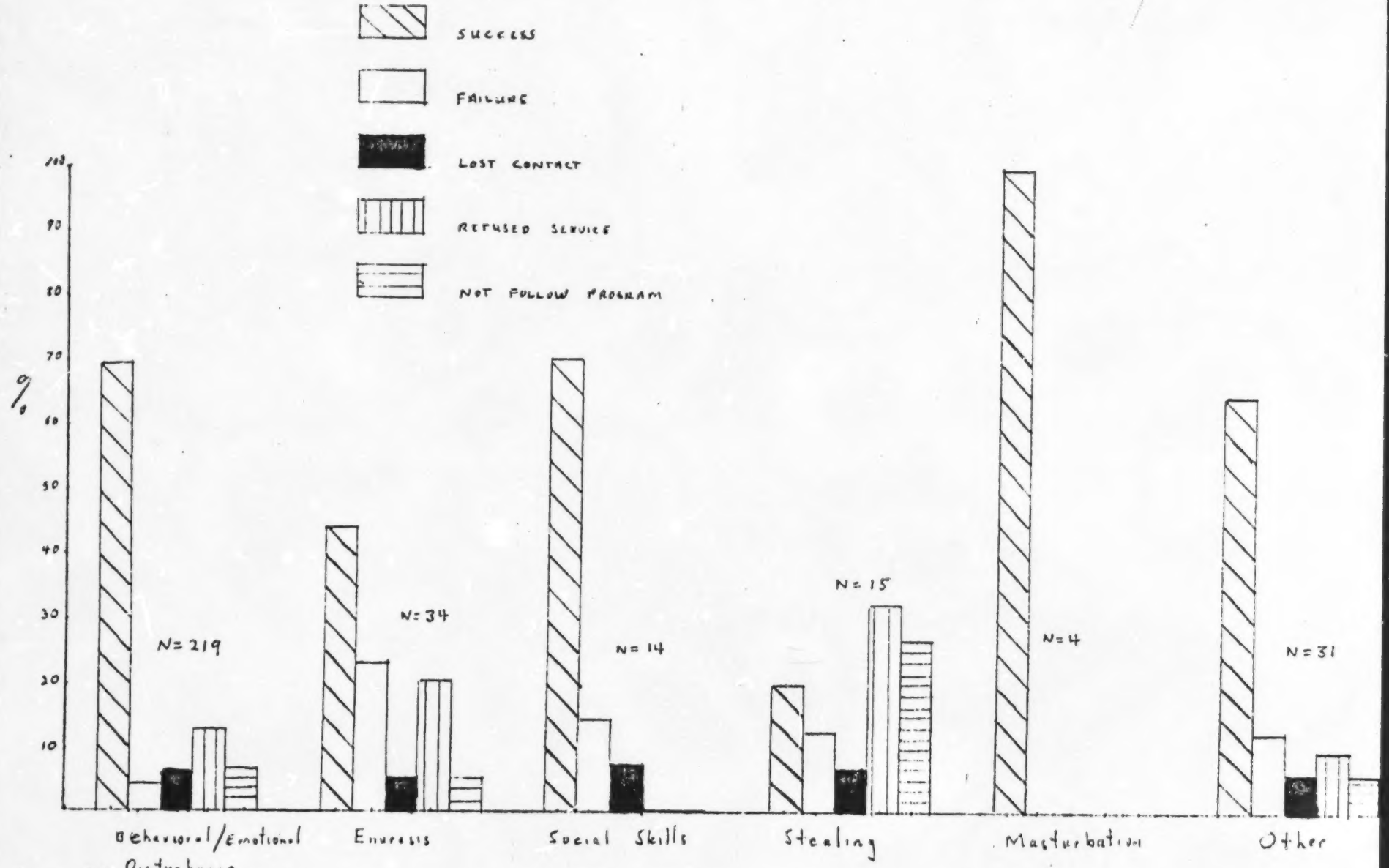

Figure 2: Outcomes with Problem Categories where Parents Cooperated with Therapist

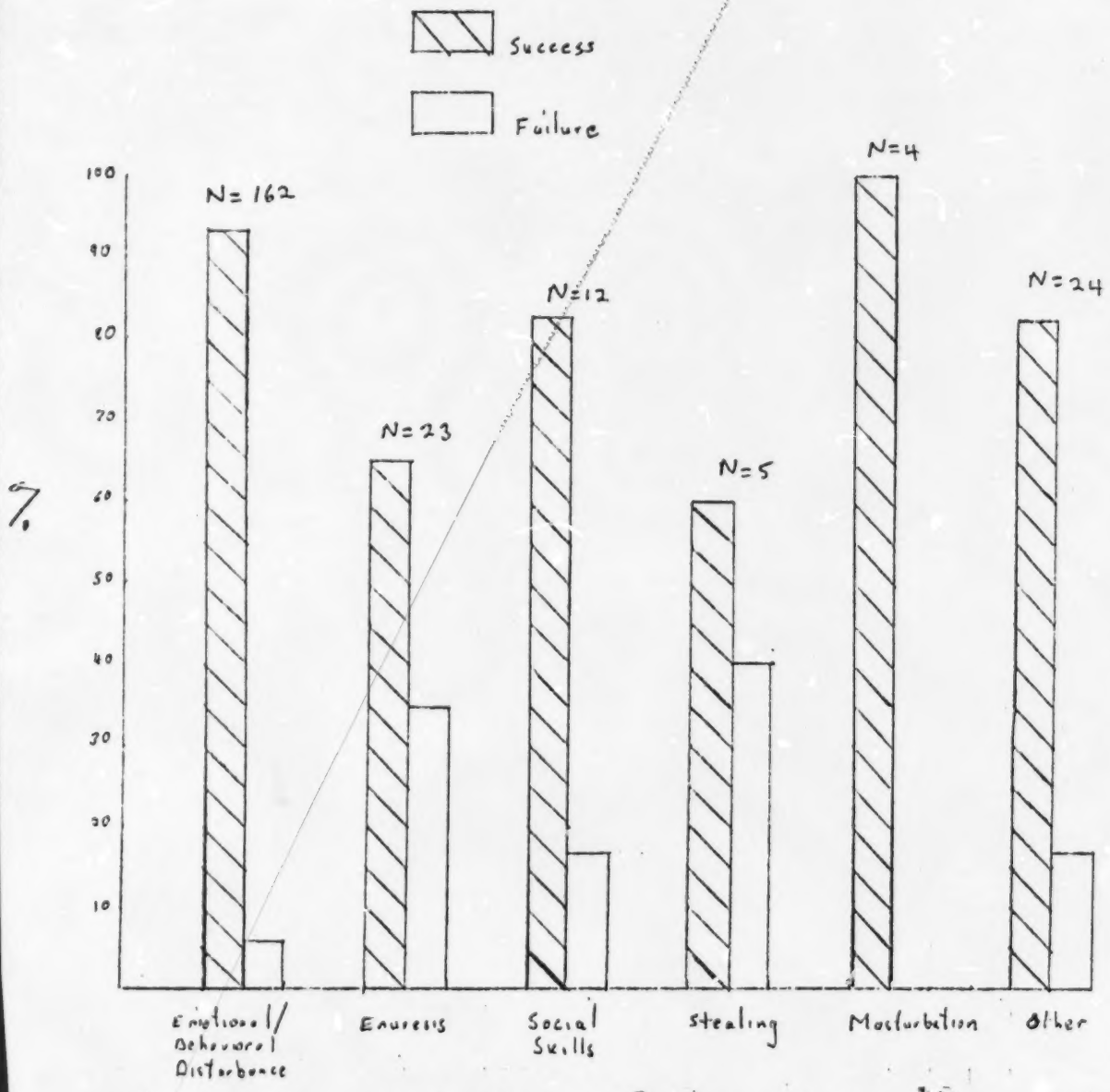

Table 1: Distribution of Presenting Problems*

	Emotional/ Behavioral Disturbance	Enuresis/ Encopresis	Lack of Social Skills	Steal-ing	Mastur-bation	Other
Number	219	34	14	15	4	31
	(69.1%)	(10.7%)	(4.4%)	(4.7%)	(1.3%)	(9.8%)

*Since some children had more than one presenting problem, the number of presenting problems (n=317) is greater than the number of identified problem children (n=245)

Table 2: Per Cent of Satisfactorily Resolved Problems

	Still Resolved on 3-Month Follow-up						
	Emotional/ Behavioral Disturbance	Enuresis/ Encopresis	Lack of Social Skills	Steal-ing	Mastur-bation	Other	Total
Probs. Res. on Termin.	66	7	6	1	1	6	87
Problems Satisfac. Follow-up	55 (83.3%)	7 (100%)	4 (67.0%)	1 (100%)	1 (100%)	6 (100%)	74 85%

Table 3: Average Amount of Contact Required for Each Case

	Family		Collateral		Referral Agent			Total	
	Visits	Phone	Visits	Phone	Visits	Phone		Visits	Phone
Numbers	3.2	5.6	0.3	0.9	0.8	1.1	#	4.2	7.6
Time Involved	2.9 hrs	0.9 hrs	0.16 hrs	0.2 hrs	0.2 hrs	0.2 hrs	Time	3.3 hrs	1.2 hrs
Travel Time	1.8		0.1		0.02			Travel Time 1.9 hrs	
Mileage	58.3 mi.		2.5 mi.		0.6 mi.			Mileage 61.4 mi.	

APPENDIX A

DESCRIPTION OF PROBLEM CATEGORIES

The six problem categories are described below, and a brief description of the intervention strategy used is included.

1. Emotional/Behavioral Disturbance

This category was used to describe all of the acting out behavior that is considered "normal" for children to engage in. This included such things as throwing a temper tantrum, not doing chores, fighting with siblings, etc. Even in cases where this behavior seemed extreme (i.e., going rigid, almost catatonic in a temper tantrum) it was classed as emotional/behavioral disturbance unless special programming had to be devised to deal with it.

A child might exhibit one or all of the sample of problem behaviors described below in varying degrees of severity. The consequences for these behaviors were usually either Time-Out or a natural consequence such as "if you don't eat you go hungry."

a) noncompliance
b) not keeping room tidy
c) eating problems - picky eater, poor table manners, etc.
d) temper tantrums - screaming, crying, kicking, biting, breath-holding, going rigid, etc.
e) not doing chores
f) not doing homework
g) fighting - verbal, physical
h) refusal to go to bed; not staying in bed when sent there

i) not getting washed, dressed, etc., in morning in time for school

2. Enuresis

This included both daytime and nocturnal enuresis. It also included cases of constipation, refusal to make bowel movements, and excessive soiling. The majority of cases, however, were simple nocturnal enuresis. Programming was usually not attempted if the child was younger than four years of age and/or was not daytime toilet trained.

The intervention strategy was to start with a basic program, then add successive refinements until the problem was resolved. First, a bedtime routine was established. Secondly, a token reinforcement technique for staying dry was introduced. Finally, a commercial "Wet Alarm" apparatus was used.

3. Social Withdrawal/Lack of Social Skills

This was usually a child who would not interact with other children or who was unable to interact appropriately with peer group members. Intervention ranged from placing a small child in nursery school and praising and encouraging social interaction, to individual counselling with older children (10 years - 12 years) who were having trouble relating to their peer group.

4. Stealing

Stealing occurred most often in the home (i.e., money from Mom's purse), but occasionally from stores, other children, school, etc. Intervention consisted of a program for reimbursement plus working off the value of the article by engaging in work the child did not like (i.e., cleaning oven racks).

5. Masturbation

Although this is an infrequent problem, it was categorized separately rather than lumped under "other" since there is little literature on the problem.

Masturbation was classified as a separate problem if the frequency was extremely high and/or it occurred in public (i.e., outside the home).

Intervention varied depending on the assessment of what needs the masturbation net--i.e., response to anxiety; to gain attention; to allay feelings of insecurity; a continued response to a genital irritation, etc.

6. Other

Any problem that did not fit into the other five categories was placed here. Intervention varied considerably according to the nature of the problem. A list of problems classified as "other" follows:

a) failure to stay on a diabetic regimen
b) exceptionally deviant eating habits--only eats bread and butter or Cheerios
c) nightmares
d) school phobia
e) thumb sucking
f) fire setting
g) headaches

APPENDIX B

DESCRIPTION OF OUTCOME CATEGORIES

1. Satisfactorily Resolved - Parents said that:
   a) behaviour had changed sufficiently in desired direction and/or
   b) they were better able to cope with the behaviour complained about.

0. Failure - Parents stated that:
   a) behaviour had not changed sufficiently in the desired direction and/or
   b) they were still unable to cope with the behaviour complained about.

2. Refused Service - Parents to whom the intervention program was described on the first visit but who decided not to follow through because it contradicted their own beliefs in child rearing.

3. Lost Contact - Parents failed to show up for appointments and/or were not reached after several phone calls and a letter had been sent to them.

4. Would not follow programme - Parents insisted they wanted help but would not put into effect the interventions designed for their problems (i.e., kept on spanking child rather than use Time Out.)

APPENDIX C

1. In general, how satisfied are you with the services provided by the therapist?

1	2	3	4	5
Very Dissatisfied				Very Satisfied

2. Listed below are some of the problems that were dealt with in the therapy sessions. Please rate how satisfied you are now with your ability to deal with each of the problems.

Problem #1 _____

_____

1	2	3	4	5
Very Dissatisfied				Very Satisfied

Problem #2 _____

_____

1	2	3	4	5
Very Dissatisfied				Very Satisfied

Problem #3 _____

_____

1	2	3	4	5
Very Dissatisfied				Very Satisfied

3. Are you still using the following programs that the therapist set up with you?

a) Time-Out YES_____ NO_____

If you are not using this program, could you please explain why not?

_____

_____

_____

b) Specific praise statements YES_____ NO_____

c) _____

d) _____

4. Please give us your comments and feelings about the services that were provided (use back of page if necessary).

Appendix C Continued

Response to Questions 1, 3 and 4 of the questionnaire.

1. In general, how satisfied are you with the service provided by the counselor?

Very Dissatisfied 1	2	3	4	Very Satisfied 5
2	1	7	21	50
2.5%	1.3%	8.7%	26.3%	61.7%

Comments on the service		
Favorable	48	59.2%
Unfavorable	4	0.5%
Neutral	9	11.2%
No Comment	20	24.7%
N =	81	